Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)
U.S. Department of Labor Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

Employer name and contact:

Delhaize America
Attention: Leave Coordinator
P. O. Box 10540
Portland, ME 04104
FAX 1-207-896-8998

Employee's job title: FT ASST MEAT MKT SALES MGR
Regular work schedule: 40 hrs/wk ; 5 days/wk ; shift ends by 2:30pm
Employee's essential job functions: see attached "position description" from Hannaford

✓ Check if job description is attached; JOB DESCRIPTION NOT ATTACHED

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name:
Jai MORIN ASSOCIATE ID: 1178782

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(c), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Dr. Richard Dubord, MD, 309 Unity Rd. Albion ME. 04910
Type of practice / Medical specialty: Family Practice / Geriatrics
Telephone: (207) 437-2500 Fax: (207) 437-2501

PART A: MEDICAL FACTS

1. Approximate date condition commenced: Approximately (8 yrs) ago → First seen by me
Probable duration of condition: Approximately 10 yrs DOS 11/3/2013

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
✓ No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
every 1-3 mos since first visit over 3 yrs. ago
(First visit: 11/3/2013)

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Will the patient need to have treatment visits at least twice per year due to the condition? ___No ✓ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ✓ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ✓ No____Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓ No ___Yes. If so, expected delivery date: ________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition: ✓ No ____Yes. (see Ques 4 for further clarification)

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

DIAGNOSIS - Chronic Neuropathic Pain and Fatigue Secondary to Lyme Disease and Complications

Pts severe fatigue and pain consistently escalate by [illegible] [illegible] — [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] work-related injury, as well as inability to perform his job duties. By allowing pt to [illegible] by 2:30 PM, these symptoms are [illegible] and he is then able to perform all of his job duties.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? X No___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: From__________To__________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ✓ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ✓ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
Pt is seen every 1-3 mos, and because of my schedule, pt needs to take a day off of work each visit date

Estimate the part-time or reduced work schedule the employee needs, if any:
________ hour(s) per day; ________ days per week from ________ through ________ } pt needs to be completing his daily shift by 2:30 PM

Associate 1178781

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ✓ Yes. employee to be absent from work during the flare-ups?

___ No ✓ Yes. If so, explain:

When pt experiences a flare-up, he has severe pain (especially in back, legs & [illegible]). Pain [illegible] hits coordination, judgement, ability to perform his job duties is impaired. (making him more prone to injury).

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: 1 times per 1 week(s) ___ month(s)

Duration: ___ hours or 1 day(s) per episode

Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

Please be sure to sign the form on the last page

Associate 1178781

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

3/17/16
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Associate 1178781

DELHAIZE AMERICA

March 23, 2016

Dr. Richard Dubocq
209 Unity Rd
Albion Me 04910

RE: Jai Morin

Dear Sir:

My name is Lisa Cote and I am the Supervisor in the Leave of Absence Department at Delhaize America. I am processing an LOA request for Mr. Morin. I called your office today with some follow up questions to the certification you have completed for Mr. Morin, and was advised to send the questions to you via fax. Thank you in advance for help in clarifying this request for me.

On 3/17 you completed the medical certifications forms in regards to Mr. Morin's case, indicating that he needed a reduced work schedule.

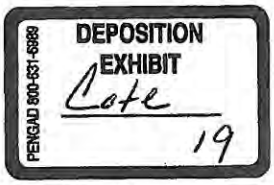
You will find attached a copy of a Facebook account for this patient's personal meat cutting business. Please note his hours of operation are from 3:00 pm -9:30 pm, and that he offers to take in customers in the middle of the night.

1) Can you please explain why this patient cannot perform his duties after 2:30 at Hannaford, but can work for himself during this timeframe?
2) Can you please explain whether the info provided has any impact to the information provided to us, on if your patient can work for us during the time of 2:30 to 9pm?
3) Does this info change your medical opinion on hours the associate can work due to his medical condition? If this does not change your medical opinion, can you explain how the associate can complete the same duties in his personal business as what is performed working at Hannaford?

Thank you for your input. We await the result if these findings. My Fax # is 207-396-2723

Lisa Cote

Lisa Cote | Supervisor Benefits Administration & Optimization | Delhaize America | Leave of Absence Administration



Delhaize America Shared Services Group, LLC | P.O. Box 1000, Portland, ME 04104 USA
T: +1 207.883.2911 | www.delhaizegroup.com

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05/02/2016 12:25 (FAX) P.001/003

Richard J. Dubocq, M.D.
209 Unity Road
Albion, ME 04910
Telephone – 207/437-5500
Fax – 207/437-5501

FAXED APR 07 2016

①

FACSIMILE TRANSMITTAL

To: Lisa Cote, Supervisor, Benefits Admin Dept, Delhaize America FAX#: [illegible]

From: Dr. Richard Dubocq Date: 4/7/16

RE: Jai Morin (DOB: 2/11/71) Your 3/28/16 Fax # of Pages (including this one): 3

- Urgent
- Please Reply
- For Review

Dear Ms Cote: I will answer your 3/28/16 fax, after having discussed its contents today c̄ Jai Morin:

Ques. ① Mr. Morin cannot safely work @ Hannaford in a [illegible] basis [illegible] regarding his business operating after 2:30 pm, he employs 5 staff to do the work, so he has the ability not to work at all on bad days. (He does not have this option when working at Hannaford). He can also decide "even" at the "last minute", not to open on a certain week. (On these occasions he has referred the customers to other local meat cutters). Also, for 11 mos of the year, the business is NOT even open. In November, the entire takes 2 weeks off work at Hannaford to be not available that one month of the year he runs his business. Finally, Mr. Morin does not use potentially hazardous machines he's expected to operate safely at Hannaford (band saw, for example) at his business.

(OVER →)

DEPOSITION EXHIBIT Cote 20 PENGAD 800-631-6989

Hannaford - 000555

05/02/2016 12:26 (FAX) P.002/003

RICHARD J. DUBOCQ, M.D.

PROGRESS NOTES (2)

PATIENT NAME: Jai Morin D.O.B. 7/22/71

DATE NOTES

DATE: 4/7/11

AGE: (2)

WT: Cont.

BP:

P:

T:

Ford response to Lisa Cote 3/23/11 letter (cont.)

Ques (2) The above description of how Mr. Morin operates his own motor cutting business does not "impact" the information that I provided. (My opinion regarding his work hours remains the same).

Ques (3) My medical opinion on hours that Mr. Morin can work due to his medical condition also remains unchanged. (Ques (1) addresses why I feel this way).

I hope that my answers adequately address your concerns. Please let me know should further details be necessary.

Sincerely,

Richard J. Dubocq MD

cc: Jai Morin

Hannaford - 000556

the companies of
DELHAIZE AMERICA | FOOD LION

P. O. Box 1000 • Portland, ME 04104

March 31, 2016

JAI MORIN
P.O. BOX 688
CLINTON, ME 04927

RE: INTERMITTENT FMLA DENIED

Dear JAI:

After careful review of your records, your request for intermittent Family Medical Leave Act (FMLA) leave of absence from Delhaize America has been denied.

Your intermittent FMLA leave has been denied for the following reason:

DOLS/Medical Certification not provided

Request Date: 2/19/2016

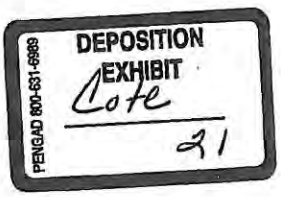
If you still require an intermittent FMLA leave of absence, please discuss this with your manager and request a new leave of absence. Absences related to this request should be addressed through the attendance policy.

Feel free to contact our HR Service Center with additional questions by calling 1-866-789-4748 or submit a Service Center ticket found on the internet or visiting ww.MyHR4U.com.

Best regards,

Benefits Department

Associate #: 1178781
CC: Supervisor or Store Manager: 8229



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May 04, 2016

Delhaize America
P.O. BOX 1000
Mail Sort 5000
Portland, ME 04104

Jai Morin
P.O. Box 688
Clinton ME - 04927

RE: Leave of Absence (LOA) - Employee's Serious Health Condition - FMLA Qualified

Associate ID: 1178781

Dear Jai:

Your intermittent leave # **244996** for your Serious Health Condition **is approved** for you to be out of work from time to time, from March 19, 2016 through March 19, 2017.

Here's what this means to you
For your intermittent leave # **244996** you can take time off **1 time(s) per WEEK** and each time off can last **8 HOUR(s).**

Family Medical Leave Act
Under FMLA, eligible employees can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- Because you have a serious health condition that keeps you from doing your job
- Caring for a child, spouse, or parent with a serious health condition
- Birth of a child
- Placement of a child for adoption or foster care
- To deal with certain arrangements when your spouse, son, daughter, or parent is serving in the military and deployed to a foreign country

A "child" includes a biological child, adopted child, or foster child, as well as a child you're acting in a parent-like role for. You can take FMLA to care for a child with a serious health condition as long as they're younger than 18 years old. You may be able to take FMLA to care for a child 18 or older, if they have a disability that makes them unable to care for themselves.

If you're caring for a covered service member with a serious injury or illness and you're that person's spouse, son, daughter, parent or next of kin, you can take up to 26 weeks of unpaid leave in a 12-month period.
You should tell us that you'll be out of work 30 days in advance. If you don't know that far in advance, let us know as soon as possible.

Maine Family Care Act
Under the Maine Family Medical Leave Act (MEFMLA), every employee who has been employed by the same employer for 12 consecutive months is entitled to up to 10 consecutive work weeks of family medical leave in any 2-year period unless employed at a work site with fewer than 15 employees. Domestic Violence Stalking Victim of a Crime. The employee must give 30 days notice of the intended date upon which family leave will commence and terminate, unless prevented by medical emergency from giving that notice. Family leave may be requested for:

- Serious health condition of the employee
- The birth of the employee's child
- The placement of a child 16 years or less with the employee in connection with the adoption of the child by the employee

PENGAD 800-631-6989 DEPOSITION EXHIBIT Cote 22

- A child, domestic partner, sibling, spouse, or parent with a serious health condition
- The donation of an organ by the employee for a human organ transplant or the death or serious health condition the employee's spouse, domestic partner, parent, sibling or child if the spouse, domestic partner, sibling, parent or child is a member of the state military forces, or the US Armed Forces including the National Guard and Reserves, dies or incurs a serious health condition while in active duty.

Family medical leave may be taken intermittent or on a reduced leave schedule.

- During FMLA leave, the Company will maintain your healthcare coverage to the same extent as if you remained working during your leave. The Company will continue to pay for your participation in the Company's group health plans, pension and retirement plans, etc. during FMLA-protected leave (up to 12 weeks), as long as you continue to pay your portion of the premium costs.
- Your portion of the premium costs will be deducted from your paycheck. Should the amount be insufficient to cover your portion of the costs, the balance may be taken from a future paycheck or billed directly to your residence.

Your Responsibilities While on Intermittent Leave

- You must immediately contact your manager or supervisor each time you will miss any scheduled work, and you must make clear that your absence is related to your FMLA-protected condition.
- You must request a continuous leave of absence by calling the **Associate Service Center** if you are expecting to be out of work more than **five consecutive (5) days.**

Manager Responsibilities While You are on Intermittent FMLA Leave

- Your manager or supervisor is responsible for tracking your leave usage.

What if you are out for medical reasons and need to file for disability?

If you are out due to your own medical reasons and are eligible for Short Term Disability please contact Aetna @ 1-877-266-2872 (All associates are required to file a claim within 15 days. If you delay beyond the 15-day deadline, you may incur a penalty of up to $500.)

If you have supplemental coverage through Continental American Insurance Company (CAIC) also call @ 1-800-524-5298.

If you should have any questions, please contact the Associate Service Center at 1-866-789-4748.

Sincerely,

LISA COTE
Leave of Absence Coordinator
Delhaize America Benefits Department

cc: 08229-STORE # 8229 W

Enclosures:
Provider Medical Update Form
Employee Rights and Responsibilities under the FMLA form

8/29/16

Dear Ginny,

As you probably remember I wrote to you in February asking for reduced schedule FMLA with scheduled shifts ending by 2:30 pm. My request was denied as intermittent FMLA. This is not what I need. I am further given 12 time off in separate blocks of time. Reduced schedule FMLA reduces the number of working hours per week or per day. My doctor states that I am not able to function well at the end of the day and he requested that you put me on FMLA that ends by 2:30 p.m. I need reduced schedule FMLA not intermittent FMLA. I was told at the time it was presented to me and you probably recall I was told I'd get that and reduced schedule FMLA were the same thing. This is not the case as I believe.

After I requested reduced schedule FMLA I have continued to be scheduled 2 to 2:30 pm. For example 8/28/16 and on 8/27/16. And again 8/26/16 until 2 p.m. on 8/26/16. This is harmful to my health. It also places undue burden on me and my co-workers. As I have stated to you, I don't feel well leaving these late shifts but feel I must to receive early as to not my doctor's recommendations. I have also mentioned to you that I have had a home nurse's aide present on these days before they left due

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Hannaford - 000550

2016-08-30 11:02 HBC8229 2078777550 >> 2078732697 P 4/4

I am again requesting that you provide me with a schedule adjustment (shifts ending by 2:30 pm) as a reasonable accomodation for my disability. If you are still unwilling to grant me this reasonable accomodation, then I request that you give me the reduced schedule (PM LA) until that time scheduling will be work past 2:30 pm. I believe that you can do this and still provide me with a full time work schedule without any undue burden on Hannaford.

This is very important so I respectfully request that you respond in writing by 9/5/16.

Thank you,

Respectfully,

Jessica Hannaford

Hannaford - 000552

06/25/2017 15:33 207-437-5501 RICHARD J DUBOCQ MD PAGE 01/06

URGENT

Richard J. Dubocq, M.D.
209 Unity Road
Albion, ME 04910
Telephone – 207/437-5500
Fax – 207/437-5501

To: Retail Business Services. Benefits Dept. FAX #: 207-396-[illegible]

From: Dr. Richard Dubocq Date: 5/16/12

RE: Jay Morin, FT Asst Mgr [illegible] Sales Mgr # of Pages (including this one): 6

- X Urgent
- o Please Reply
- X For Review

Dear [illegible], Sorry for the delay in [illegible] this form as my practice is extremely busy with very [illegible] patients!

Thankfully nothing much has changed [illegible] to the last [illegible] I sent this paperwork [illegible].

Sincerely,

[signature]

Richard J. Dubocq MD

cc: Jay Morin

Note: The information contained in this facsimile may be privileged and confidential and protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying or other use of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately by telephone at 207/437-5500 and destroy this facsimile. Thank you.

DEPOSITION EXHIBIT
PENGAD 800-631-6989
Cote
24

Hannaford - 000558

06/25/2017 15:33 207-437-5501 RICHARD J. DUBOIS MD PAGE 02/06

Employer: Retail Business Services
Mail To: An Ahold Delhaize Company
PO Box 1000 - Mail Sort 9000
Portland, ME 04104
Fax #: 207-396-3998

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

Leave # 285986

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Retail Business Services Fax Number: 207-396-3998

Employee's job title: FT ASST MEAT MKT SALES MGR Regular work schedule: ______

Employee's essential job functions: ______

______

Check if job description is attached: ___

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Jai Marin ______ ______
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Richard J. Dubois, MD, [illegible] Unity Rd, Albion, ME 04910

Type of practice / Medical specialty: Family Practice / Geriatrics

Telephone: (207) 437-5500 Fax: (207) 437-5501

 CONTINUED ON NEXT PAGE Form WH-380-E Revised May 2015

Retail Business Services

Authorized Representative Form

The Associate should fill out this form and return to the Benefits Department with the Medical Certification when the doctor completes the form.

Leave # 285936

The Benefits Department is in receipt of a leave of absence request for:

Associate Name: Jal Morin
Associate Number: 1178781

I, Jal Morin, understand this agreement will allow the Benefits Department to contact my Health care provider or the Company's disability provider for purposes related to my medical leave of absence. I further understand that this agreement will allow the Benefits Department to request any documentation that may relate to this leave of absence.

I understand this agreement is voluntary and made solely to support my leave request.

Associate's Signature: ______________________ Date: ______________

You may also choose to allow the Benefits Department to communicate with a relative or other person regarding your leave of absence. If you so choose, please provide that person's name and contact information and sign the authorization below.

I, Jal Morin, give permission for the Retail Business Services Benefits Department to discuss my leave and medical information with the following relative or person:

Name: [redacted]
Contact #: ______________

I, Jal Morin, I received the full opportunity to read and consider the contents of this permission. I understand that, by signing this form, I am confirming my permission for the above-named person to receive information about my leave of absence, including but not limited to my protected health information. I understand that the above-named person may further disclose my information, and any subsequent disclosure may not be protected by Federal or State privacy laws.

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:
HIPAA Privacy Official
Phone #1-866-789-4749
Fax # 1-207-396-3998

I understand that revocation of this permission will not affect any action taken in reliance on this authorization before receipt of notice of revocation.

Associate's Signature: [signature] Date: 5/1/17

If the associate's leave of absence is to care for a relative, state the relative's name and relationship

Name: ______________________ Relationship: ______________

I, ______________ (name of relative that is being cared for), give the Benefits Department permission to contact my Healthcare Provider for information that pertains to the associate's (stated above) leave of absence to care for me.
Signature of the relative that is being cared for if other than a child.

______________________ Date: ______________

If the associate has Health care Power of Attorney (HCPOA), and the relative is unable to sign this document please submit a copy of HCPOA

PART A: MEDICAL FACTS

1. Approximate date condition commenced: About 10 years ago [I [illegible] on 1/3/13]

Probable duration of condition: About 10 years

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
✓ No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Over the past 4 years (since 1/3/13) about every 1-3 mos.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ✓ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No ✓ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓ No ___ Yes. If so, expected delivery date: ______

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ✓ No ___ Yes.
(EXCEPT FOR WORKING EXTENDED WORK HOURS)

If so, identify the job functions the employee is unable to perform:

N/A

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Diagnosed to suffer from Chronic Myofascial pain [illegible] secondary to Chronic Lyme Disease and Coinfections. This patient [illegible] [illegible], when it comes to his medical condition interfering with his work, is that his fatigue and pain escalate through the course of the morning and peak by mid afternoon. When this occurs he becomes less efficient and [illegible]. This in turn makes him more prone to work-related injury (i.e. cutting self on butcher knives!) and reduced ability to

adequately perform his job duties. By allowing him to leave work every day at 2:30 PM, these shortcomings would be avoided, resulting in enhanced safety and better job performance! (Along with better health of patient!)

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ✓ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: N/A

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ✓ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ✓ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Pt needs to take day off work every 1-3 mos to be seen at my office.

Estimate the part-time or reduced work schedule the employee needs, if any:
Pt needs to finish work daily by 2:30pm No exceptions!!
___ hour(s) per day; ___ days per week from ___ through ___

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ✓ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ✓ Yes. If so, explain:

When patient experiences flares he cannot efficiently or safely perform his job duties & he needs to stay out of work that day.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: 1 times per 1 week(s) ~~month(s)~~

Duration: ___ ~~hours~~ or 1 day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

This patient is extremely motivated to work and has been a "model employee" for many years. It bothers him that he cannot be as flexible in his hours as being requested, because of his medical condition. He's also most frustrated, however, at the employer's lack of accommodating anything as simple as work hours/quitting time after giving so many years of dedicated quality service!

Page 3 CONTINUED ON NEXT PAGE Form WH-380-E Revised May 2015

[redacted]

Signature of Health Care Provider

5/16/13
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

As required by law, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. §7616; 20 C.F.R. § 825.306. Persons are not required to respond to this collection of information unless it displays currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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Form WH-380-E revised January 2009

Hannaford - 000563

Retail Business Services

May 19, 2017

Retail Business Services
An Ahold Delhaize Company
P.O. BOX 1000
Mail Sort 5000
Portland, ME 04104

Jal Morin
P.O. Box 688
Clinton ME - 04927

RE: Leave of Absence (LOA) - Employee's Serious Health Condition - FMLA Qualified

Associate ID: 1178781

Dear Jal:

Your intermittent leave # 285936 for your Serious Health Condition is approved from April 7, 2017 through April 7, 2018.

Here's what this means to you
For your intermittent leave # 285936 you can take time off 1 time(s) per WEEK and each time off can last 8 HOUR(s).

You're eligible for job protection under the Federal leave law listed below:

Family Medical Leave Act

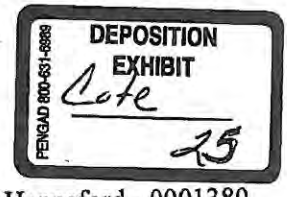
Under FMLA, eligible employees can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- Because you have a serious health condition that keeps you from doing your job
- Caring for a child, spouse, or parent with a serious health condition
- Birth of a child
- Placement of a child for adoption or foster care
- To deal with certain arrangements when your spouse, son, daughter, or parent is serving in the military and deployed to a foreign country

A "child" includes a biological child, adopted child, or foster child, as well as a child you're acting in a parent-like role for. You can take FMLA to care for a child with a serious health condition as long as they're younger than 18 years old; You may be able to take FMLA to care for a child 18 or older, if they have a disability that makes them unable to care for themselves.

If you're caring for a covered service member with a serious injury or illness and you're that person's spouse, son, daughter, parent or next of kin, you can take up to 26 weeks of unpaid leave in a 12-month period.
You should tell us that you'll be out of work 30 days in advance. If you don't know that far in advance, let us know as soon as possible.

Maine Family Care Act



Hannaford - 0001380

Under the Maine Family Medical Leave Act (MEFMLA), every employee who has been employed by the same employer for 12 consecutive months is entitled to up to 10 consecutive work weeks of family medical leave in any 2-year period unless employed at a work site with fewer than 15 employees. The employee must give 30 days notice of the intended date upon which family leave will commence and terminate, unless prevented by medical emergency from giving that notice. Family leave may be requested for:

- Serious health condition of the employee
- The birth of the employee's child
- The placement of a child 16 years or less with the employee in connection with the adoption of the child by the employee
- A child, domestic partner, sibling, spouse, or parent with a serious health condition
- The donation of an organ by the employee for a human organ transplant or the death or serious health condition the employee's spouse, domestic partner, parent, sibling or child if the spouse, domestic partner, sibling, parent or child
- If the spouse, domestic partner, sibling, parent, or child is a member of the state military forces, or the US Armed Forces including the National Guard and Reserves, dies or incurs a serious health condition while in active duty.

Family medical leave may be taken intermittent or on a reduced leave schedule.

- During FMLA leave, the Company will maintain your healthcare coverage to the same extent as if you remained working during your leave. The Company will continue to pay for your participation in the Company's group health plans, pension and retirement plans, etc. during FMLA-protected leave (up to 12 weeks), as long as you continue to pay your portion of the premium costs.
- Your portion of the premium costs will be deducted from your paycheck. Should the amount be insufficient to cover your portion of the costs, the balance may be taken from a future paycheck or billed directly to your residence.

Your Responsibilities While on Intermittent Leave

- You must immediately contact your manager or supervisor each time you will miss any scheduled work, and you must make clear that your absence is related to your FMLA-protected condition.
- You must request a continuous leave of absence by calling the **Associate Service Center** if you are expecting to be out of work more than five consecutive (5) days.

Manager Responsibilities While You are on Intermittent FMLA Leave

- Your manager or supervisor is responsible for tracking your leave usage.

If you should have any questions, please contact the Associate Service Center at 1-866-789-4748.

Sincerely,

LISA COTE
Leave of Absence Coordinator
Retail Business Services Benefits Department

cc: 08229-STORE # 8229 W

Enclosures:
FML Certification Employee Own Illness
Employee Rights and Responsibilities under the FMLA form

Hannaford - 0001381

Leave # 244996

Provider Medical Update Form

SECTION I: Notice for the HEALTH CARE PROVIDER

Jai Morin **Associate Id#: 1178781** is on a leave of absence associated with a medical condition. Such leave may be protected under the Family and Medical Leave Act (FMLA). Medical updates from the associate's health care provider are required to maintain his/her leave status and employment with Delhaize America. Below is the information required for a medical update. Please complete and return by U.S. Mail or fax.

U.S. Mail: Delhaize America, Benefits Dept.
Attention: Leave Coordinator
PO BOX 1000
Mail Sort 5000
Portland, ME 04104
Fax: 207-396-3998

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____
2. Probable duration of condition:_____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___ Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No___Yes

Leave # 244996

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No____ Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

3. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

4. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

5. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____
_____
_____
_____
_____
_____
_____
_____

PART B: AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

Leave # 244996

Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day; _____ days per week from _____ through _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____ Yes..

Is it medically necessary for the employee to be absent from work during the flare-ups?
____ No ____ Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Leave # 244996

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013